Great Lakes Region Asthma Forum
February 8-9, 2007

Table of Contents

Part A: Plenary Session

Part B: Breakouts Sessions - Model Programs

Region 5 Asthma Website is http://www.epa.gov/region5/air/asthma

Part A: Plenary Session

1. Introduction Ice Breaker - "What would you do if you received $5,000 for your Asthma Program and $5,000 for yourself?"

Illinois

1. Use it to help clients remove asthma triggers that deal with home environment issues. 1) Pay off debt. (1/2) 2) Deposit into savings account.
2. Spacers for all of the students – part time staff, temp, to work on school team to check indoor air quality. For me – Spa.
3. Go into the community to educate parents about asthma and obesity – flyers. For me - $2,500 for Grandparents and $2,500 for myself to go on a shopping trip.
4. Create a series of short online programs that teach people how to use inhalers and manage their asthma. Donate it to ELPC & Environment Illinois to reduce mercury, particulate pollution and help prevent asthma.
5. Buy $10K worth of meds/spacers for the uninsured patients we serve (on the Asthma Vans in Chicago). www.mobilecarefoundation.org
6. Enhance clinical fusion data system for five schools.
7. More focused on data more clinical fusion for schools data sources. Schools health centers DHS. Give to my parents.
8. Purchase peak flow meters for clinic and more handouts designed for our clinic. Pay tithes 10%.
9. Develop an excellent world asthma day (invite noted speaker), more asthma materials. Self – travel.
10. Primary care education. Research project on the effect of high copays.
11. Pay our LHES bonuses. Pay a bill off.
12. More outreach for asthma triggers. Vacation
13. PT/contractual staff to implement some of the educational activity and leg work for our asthma network. Self – Invest/save/use for summer vacation plans.
14. Program outreach. Grandchild's college fund.
15. Nebulizer equipment and school speakers/program, clean up mobile class areas. For me – school, loan, and mortgage.
16. $5,000 for program = WIC and $5,000 for me = mortgage.
17. Try to find a way to invest in drug program for medicine and teaching about asthma. Self – donate half to asthma program.
18. Money to support care management for asthma materials. For self – donate a portion and spend a portion on my comfort zone.
19. Create comprehensive multimedia/visual/bilingual educational material for asthma management for parents/teachers/children.
20. Myself – Buy a car to get around easier and reach communities.
21. Mattress covers and dust barriers. Down payment on new car.
22. Hire grant writer to find additional funds to grow our programs. Personal – Vacation for my 40th birthday.
23. I.D. effective interventions for asthma. Personal – Children's college fund.

Indiana

1. Purchase items for families who can't afford to reduce triggers in their homes. PSA's to increase asthma awareness. Me: Family rafting trip to Grand Canyon or Glacier Park trip for 3 weeks.
2. Target minority population using faith-based or race based organizations. Donate ½ to program and vacation with other half (some where warm and watery).
3. $5,000 Program – New program – Help set air direction, business cards, logo – brochures, establishment, and spacers for schools. $5,000 – Windows for house or down payment on a new car.
4. For program – Provide to another local program. For Me – Pay off some school loans and go on a cruise.
5. Program – Either toward matching funds for another staff person or vacuum cleaners. Me – Either new windows for house or "Colts Season Tickets".
6. Program – Awareness and PR. Vacation in some place warm (with wife only, no kids).
7. Story book display for health fair/community outreach will help and staffing activities. Family trip for all of us together and relax.

Michigan

1. $5,000 to partner with the Inner City Asthma Program to support Asthma care/education for the underinsured. $5,000 to college tuition.
2. Program: Procure more services and goods for clients in the Disease Management Program. Example: furnace repair, encasement, dehumidifiers, air conditioners, and mileage. Me: Take a long vacation so I can be more relaxed and effective when I come back.
3. Hire staff and materials. Purchase materials for patients. Example: mattress covers, spacers, and PFM
4. $5,000 for our program would be spent partly on home remediation, community conferences, getting out to schools (mainly parents in schools) money to further educate PTA. $5,000 for myself = vacation (travel), and education
5. Hire communications specialist for products/presentation. Kitchen remodeled.
6. Program – training community health workers and pay them stipends to conduct asthma education in the community. Put money into the program since funding is a major issued and try to get people/organizations to match my donation.
7. $5,000 to Program: Where need is greatest perhaps: new research software. Standardized Data Program: Hotline/State or local level. Direct to resources.
8. Incentive to members for completing home asthma education. Write off gift. Develop and implement regular educational sessions for patients & asthma.
9. Go forward making more home visits and evaluations of home environments. Pay Macy's bill and go to Disney World.
10. Seed money towards science research "incident asthma". Show boat trip somewhere and boat cruise.
11. Purchase resources that are really needed for Genesee County.AE-C $300, family $1,000 and pay debt $3,000.

12. Reproduce AO and Asthma education materials. Refund a WRA training program. Trip for my wife and I.
13. $5,000 for program – Employ someone to make personal contact/phone with every school district in our three county service area to schedule educational presentations for teachers, coaches, support staff and parents. $5,000 self – pay someone to paint interior of new addition.
14. As MACN Coordinator, I would use funds for a more inclusive summit of asthma coalitions and grant writer or update to website. Mexico vacation with an updated computer so, I can work on the beach.
15. Outreach programs – After school functions, summer camps, and new moms. Honestly – bills and education

Minnesota

1. $5,000 program – asthma awareness give away stuff (t-shirts, hats). $5,000 me – Ideally – $2,500 guitar, $2,500 amp – realistically – wife
2. Buy low/no-cost carbon monoxide alarms for immigrant populations. $5,000 – Tuition for children's education.
3. Funding to sustain efforts of "Catching our Breath", asthma initiatives: Home visits to families in need of asthma education, environmental assessments and interventions. Education and outreach to community working and children. Face-to-face meetings with coaches, educators, day cares, churches, parishes and nurses. Provide resources, supplies, and medicine. PSA's ongoing monthly. Training, networking with health care providers to provide better asthma management practices. Build local asthma coalition.
4. Asthma – Health educator to meet with every student diagnosed with asthma, to go into the schools and do education with the teachers. Spanish Education efforts.
5. $1,000 incentives to Clinics to encourage direct referrals to quit smoking programs for parents of children with asthma who smoke and adults with asthma who smoke.
6. $5,000 for program – Purchase low-cost asthma environmental intervention products such as bed encasements, air cleaners, and vacuum cleaners. $5,000 for self – travel: return to China or go to Australia.
7. Hire person to train public health nurses who do home visiting on asthma education and environmental intervention.

Ohio

1. $5,000 Program – Host an Asthma Awareness breakfast/luncheon, fees for center etc… My $5,000 – Use it for seed money to draw participants that need to attend.
2. Use funds to diagnose asthma. Use funds to treat conditions.
3. $5,000 Program: Re-evaluate coalition functioning, revise/update goals/objective, share committee work, and full coalition meeting. $5,000 self: Go on a trip and put some towards mortgage.
4. $5K for my program – Use these resources to provide educations/awareness of our clients and asthma. My $5K – Would find a way to put it into program and keep $100 to buy a pair of shoes!!!

5. $5,000 – Invest $500 in with programs that demonstrate best practices. $5,000 – Give it to the first person to ask me for it. Hurry, it could be you!!!
6. Program – Integrate into program as incentives for participants. Example: gift cards; enlist corporate support and gifts in kids. My $5K – Add to pot. $5K is not much.
7. $5,000 for program – scholarship for traveling/training.
8. $5,000 for self – for someone to attend a meeting like this. Go to the Carribean.
9. Program – buy equipment for homes of families with person with asthma.
10. Me – vacation – warm & sunny.

Wisconsin

1. Buy reagents for sampling for community organizer. Pay off my car.
2. More direct interventions for minority populations. Save for a house.
3. Donate $5,000 to program. Accept donation. Public service announcements. Community workgroups and local providers to asthma awareness.
4. Set-up asthma group visit model and main pediatric clinic in our health system. Self – Offer reward/incentive to those who participate in asthma group visit model and involve the media regarding asthma awareness/promotion and group visit model outcomes.
5. Assist underserved population with meds., clinical care, education, and home assessments. Self – Vacation in Europe and Alaska.
6. Computer integration to compliment systems integration. Self – Continue education.
7. Altruistic – Fund more parent volunteers and community health workers. Self – family vacation in South African Safari and give a donation to the Church.
8. Spend $5,000 on marketing, publicity, and hire ad agency. Self – Put $5,000 into savings.
9. Send 20 kids to summer Asthma Camp WIKIDAS. Self – Send money to Ireland.
10. Put money towards funding more community health workers. Put money into child's college tuition fund.
11. Make education packets and get them out to the population I serve. I work with SSI, Badger Care, and Public Aid Pt's in Wisconsin.
12. Expert asthma specialist in the schools.
13. $5,000 (Wisconsin Asthma) – Northwood Asthma Coalition. $5,000 (MW) – pay off the pick-up.
14. Both – put it toward school based asthma care.

2. Presentations

Refer to external slides (in pdf format) on U.S. EPA Region 5's Asthma Website at **http://www.epa.gov/region5/air/asthma**

a. Dave Rowson – National Asthma Program
b. Shelly Stoll – Asthma Health Outcomes Project (AHOP)
c. Lisa Cauldwell – Environmental Triggers of Asthma
d. Model Programs – Asthma Alliance of Indianapolis, Fight Asthma Milwaukee (FAM), Genesee County Childhood Asthma Task Force, and, Priority Health/Asthma Network of West Michigan

3. State/Tribal Session

Refer to external State Summaries for additional information at U.S. EPA Region 5's Asthma Website at **http://www.epa.gov/region5/air/asthma**

Tribal:

Kevin Koski spoke for Bois-Forte. Bois-Forte has received funding from U.S. EPA Region 5 for the 5th year and has focused on indoor air quality, specifically mold and moisture. Bois-Forte works with Region 5 tribes and trains their housing and/or environmental departments to monitor air quality. It also does quarterly inspections for approximately 100 homes.

David Jones spoke for the Nottawaseppi Huron Band of Potawatomi. He has seven county service areas and had teamed up with health and environmental department to assist members in receiving healthcare and doing environmental work at the same time. This environmental works focuses on environmental triggers. The Tribe has a high rate of smoking and he has been educating parents on how they can discourage their children from smoking. He is also working with the school district to make training interesting for students. The next three steps he sees are outreach, outreach, and outreach.

State Asthma Programs:

IL: - Key asset from the state includes the integration with other Chronic Disease Programs and WIC Agencies. Their offer to communities was to provide satellite programs targeting school staff from child care through college, on programs that offer the opportunity for asthma education and training for all school staff. Their request to their communities was to inform the state program of community asthma program and types of activities (i.e. trainings, educational opportunities, etc.) they want and need & continue to be involved in strategic planning.

Chandana Nandi spoke representing Illinois. She noted that the Illinois Department of Health funds 19 asthma coalitions in the state, with a significant focus being the satellite programs for schools.

IN: Key asset from the state includes the availability of data and surveillance system. The offer to communities is to help support and promote community programs' activities. The state is requesting from its communities to identify and take advantage of resources when available (i.e. Federal grants, foundation grants, in-kind help from partners).

Marcie Memmer spoke representing Indiana. One of the advantages that Indiana has is the availability of a data and surveillance system. State law gives the Indiana Department of Health access to hospitalization and ER records for asthma treatment. This allows them to tie radio and television ads to asthma hot-spots.

MI: Key asset from the state program is the Michigan Asthma Communication Network, which is the communication link between the State, partners, and the public. The offer to

communities is to provide the Michigan Coalition Modules, which allows for funding opportunities to support their work through the Workplan. The request to communities is to increase partnerships with the Federally Qualified Health Centers & support Case Management by certified asthma educators.

Charlyn Primous spoke representing Michigan. She spoke of the Asthma Communication Network. This has a webpage, phone number and newsletter to spread information. It acts as a centralized location for the distribution of information. They also have Asthma models that can be tailored to a specific need.

MN: Key asset from the state program is that it has multi-disciplinary staff that can offer technical assistance on variety of issues. In addition, Intra-department coordination/collaboration occurs and representatives from several programs meet regularly. The offer to communities is to provide resources that can be replicated, such as the Managing Asthma in Minnesota Schools manual. The request to communities is to share their asthma priorities and what the community programs are doing (related to specific activities) on asthma

Laura Oatman spoke representing Minnesota. The Minnesota Department of Health asthma program has five multi-disciplinary staff members. Much of its focus is on schools, including general training sessions on managing asthma and specialized training for coaches. The program also includes school walkthroughs.

OH: Key asset from the state program is the provision of technical expertise on coalition building and data and surveillance. This is how it contributes to the development of resources and resource building. The offer to communities is the participation and support of local coalitions and support for development of new coalitions or integration of asthma into broad-based health coalitions. The request to communities is to provide information to conduct an assessment for asthma needs in the state.

Barbara Hickcox spoke representing Ohio. Her program focuses on coalition building assistance. It also supports existing coalitions that are challenged by their limitations.

WI: Key asset from the state program is the support structure of the Wisconsin Asthma Coalition (WAC) which is provided by both Wisconsin Department of Health and Family Services and Children's Health Alliance of Wisconsin, as well as multiple partners. Also, the fostering of communication channels between WAC and local asthma coalitions is another major asset. The offer to communities is information sharing at WAC Meetings & through the WAC Newsletter in order to update communities on projects like the nationally recognized Environmental Tracking. The request to communities is to identify ongoing needs and gaps & share successes with the WAC.

Kristen Grimes of CHAW spoke about their role in sharing information with partners through the State Plan-focused meetings, newsletter, and other mechanisms. Christine Rameker from WDHFS spoke about surveillance and other data being collected and discussed the

Environmental Tracking project. In addition, the unique support of WAC shared between CHAW AND WDHFS was covered.

4. Request/Offer Section

Request & Offer Session

This was an opportunity for participants to ask for support for their asthma programs as well as offer commitments to their communities and regional colleagues.

U.S. EPA Region 5 Offer:

- Region 5 Grant RFA Announcement will be sent out to participants.
  - National & Regional
- Website information will be emailed out
- Notes from the Asthma Forum will be sent to participants and posted on the Region 5 Website.
- USEPA Region 5 will go visit Fort Wayne, Indiana coalition, and any other coalition as travel allows.

FAM/Milwaukee/16th Street Health Clinic:

- Copy of their Asthma Tool Kit is available. Send email request to Erin Lee for Tool Kit request.
- Share information with other coalitions.
- Look at examples of cigarette tax
- Look into smoke-free policies
- Look into more bus retrofits
- Look for Grant Support.
- Revitalizing Environmental Policy & Advocacy

Detroit Health Department:

- Get money to address disparities, and track health outcomes.

CDC:

- Work through states, but CDC Website has resources for those focused on interventions.
- Website: Health (CDC Asthma website address) http://www.cdc.gov/niosh/topics/asthma/ for nurses etc.
- Healthy You – adolescent asthmatics
  - Centers for Disease Control – Asthma: Children and Adolescents www.cdc.gov/asthma/children.htm

Minnesota Department of Health Request:

- Region 5 should link to state Asthma Webpage's.
  - EPA, Region 5 response – Although headquarters has links, Region 5 Website will be revised to include state links.

U.S. EPA National Asthma Program:

- Headquarters – CDC/U.S. EPA will continue to work together.
- National Asthma Forum is coming up and all Great Lakes Asthma Forum participants are invited to attend..

Request: Send out information on EPA's Asthma Website at (www.epa.gov/asthma) and (www.asthmacommunitynetwork.org)

IN:

- As long as National and/or Regional Asthma meeting occurs, it will contribute to program support.

Chicago Department of Public Health:

- Will work with Headstart program, to focus on integrating asthma activities into environment.

IL:

- Barrington – Train all nurses in operating with Open Airways Asthma 101.
- Host meeting to bring Karen Meyerson from West Michigan to speak.
    - Response: Karen Meyerson offered to come.

MI Insurance Representative:

- Implement West Michigan (Karen Meyerson's) and Priority Health Program.

Genesee County, MI:

- Able to accomplish interventions with support and partnerships with Michigan Department of Health - Asthma Program, Michigan Asthma Coalition, American Lung Association, Schools, HCP, and PHE.

School nurse from Barrington, Illinois:

- Goal: Have all of our nurses trained in a session from ALA.
    - **ALA** offered to come out to train instead of having to come to Chicago.

Chicago Department of Public Health:

- Good working relationship with Chicago Department of Youth Services – will talk with them to integrate asthma activities into their enrollment.

5. Sharing Board Notes

Sharing Board

1. See Karen Meyerson for Michigan's Asthma Resource Kit (MARK)
2. Asthma Initiative Michigan – www.GetAsthmaHelp.org
3. Communities in Action for Asthma – Friendly Environments Online Network – www.AsthmaCommunityNetwork.org
4. Please visit www.GetAsthmaHelp.org for more information about asthma management, Michigan Asthma Management, Michigan Asthma Coalitions, and

protection resources. On the site, you will find asthma statistics. MACH surveillance report and the MARK. Please visit and leave comments.

5. Michigan Emergency Department Discharge Instructions: www.GetAsthmaHelp.org/Flare if you would like a copy of Michigan's revised strategic plan, please contact Charlyn Primous at cprimous@alam.org.
6. Request to communities: Illinois Asthma partners and consortia have been instrumental in developing State Plan, other documents and training.
7. Illinois offer to communities: Satellite Program - based off needs assessment to schools; offers education for staff (child care through college). Topics have included asthma and physical activity.
8. Illinois – Key asset: Integration and other chronic disease programs and WIC agencies. (See State Summary)
9. Illinois we want partners to remain active in strategic planning and letting us know what types of materials/activities they want.
10. C.H.E.S.T.- Has a good booklet about building a coalition and it includes sustainability. www.chestnet.org
11. Schools offer hearing and vision screening to students. Why not asthma screening at least for those who are interested in sports/activities participation?
12. CDC's website keyword search – Asthma –Evaluated materials - Effective interventions available. www.cdc.gov
13. Register your e-mail address to receive grant funding announcements by subject "Asthma". See www.grants.gov
14. Project Green Fleet – Minnesota Retrofit school buses to decrease diesel particulate inside school buses. (& outdoor air pollution reduced)
15. Marion County Health Department – Website: MCHD.com Housing code is Chapter 10 under "The Code".
16. National Environmental Leadership Award in Asthma Management for health plans and health care providers. www.asthmaawards.info Deadline: Feb. 16, 2007
17. 2007 Communities in Action for Asthma – Friendly Environments National Asthma Forum – May 31 – June 1 in Washington, D.C. www.epasthmaforum.com
18. "Controlling Asthma: What you need to know". Clinical patient education tool. American Lung Association of Minnesota (651) 227-8012.
19. Suburban Asthma Coalition - www.suburbanasthma.org
20. Website: www.nhlbi.nih.gov/guidelines
21. Controlling asthma in American cities – Minneapolis & St. Paul. www.alamn.org/ American Cities.

6. Strength/Challenge

Some discussion of people reporting on their main strength and challenge

State Asthma Program
Strengths/Challenge – 10 local coalitions, partnership with them and other coalition.

Tribe
Strengths –

Challenge – Trying to get people to participate.

Local Coalition
Strength – Health screens for asthma.
Challenge – People worry about who's seeing their information, identify theft – fraud, resources, money, manpower.

Coalition
Strength – Asthma Coalition Network.
Challenge – They only have one office, manpower and dollars.

State Asthma Program
Strength – Preventing asthma in childcare centers, work with ALA on medical aspects, 6 childcare centers have agreed to join, getting other childcare centers in area on board through word of mouth, ozone issues, etc.
Challenge – Communication, money, low income.

Tribe
Strength – Have a lot of health fairs and booth, women's, men's wellness days, 5-6 health fairs per year.
Challenge – Not enough educated members in the health, environment field, would help if community would hear message from someone from the tribe so they can relate.
-Do something that creates a strong visual identity/activity that would strike the passerby.

Local Coalition
Strength- Healthy home concept, utilizes university and students.
Challenge- Competition of resources, between agencies and within the same agency.

7. Discussion Topics

Sustainability is a key factor in fighting Asthma. This involves resource development, institutionalization, system change (possibly through legislation) and capacity building. There are several ways to increase sustainability. These include planning principles, evaluating success, nurture ongoing communications and public relations, recruiting members thoughtfully, and prioritizing support for coalition infrastructure.

Controlling the asthma environment is also key in fighting Asthma. Allergens, irritants, infections, rhinitis, and sinusitis must be controlled. Second-hand smoke, pets, dust mites, molds and pests can also trigger asthma. Water and moisture control, including the use of dehumidifiers, can help prevent asthma.

The National Community in Action Asthma Network Website can be a useful tool. It is found at http://www.asthmacommunitynetwork.org/. It has message boards, contacts, and information about the National Forum in May. It also has a mentoring program.

An Asthma Registry provides important information about asthma. It includes claims data, registry rules, missed services and the ratio of medication. It also categorizes patients listed on the registry. Those considered "high risk" often receive home visits and/or consultations. Medium and low risk entries receive mailings. It allows people with a particular condition to receive tailored care and pinpoint services.

Coalitions are also helping the uninsured asthma patients to receive medical car. The coalitions often refer patients to low cost or free clinics. They aid the uninsured in applying for Medicare, Medicaid, or Prescription assistance. They also provide resource guides which list local, state, or national assistance programs, provide forms, and links to helpful websites.

Part B: Break-out Sessions with Model Programs

Priority Health:
(With support from Asthma Network of West Michigan)

Attendees: Mary Cooley, Manager of Case and Disease Management
Ruth Kavanagh, Case Manager, Medicaid Team

Priority Health, a managed care organization established in 1986 with 290,000 members, has worked with the Asthma Network of West Michigan (ANWM) since 1999 as partners to provide case management services to Priority Health's managed Medicaid pediatric population with moderate to severe asthma on a fee-for-service basis. Priority Health has extended this relationship to include select commercial patients and adults with asthma who are served in an adult asthma clinic setting or through case management services. ANWM and Priority Health have had a positive impact on reduction of hospital utilization, emergency department visits, and medication use among children with asthma.

http://www.epa.gov/asthma/leadership_award_2007.html
http://www.epa.gov/asthma/pdfs/priority_health.pdf

Key Point (1): Integrated case management

- Telephonic program
- One-on-one patient counseling

Key Point (2): Physician Involvement

- Registries
- Workgroup
- Incentive Program

Key Point (3): Health Outcomes

- Database
- ER Visits
- Med. Use Reductions

Fight Asthma Milwaukee (FAM) Allies:

Attendees: Laurie Smrz, Asthma Program Coordinator**, Erin Lee**, FAM Allies Coordinator**, Richard Gaeta**, Lead Hazard Prevention Manager**, Holly Nannis,** Diabetes & Asthma Program Manager**, Vicky Edwards,** Community Organizer**, John Meurer,** Director and PI of FAM Allies**, Kathleen Levac,** Chair of Steering Committee, FAM Allies

FAM Allies strive to eliminate the root causes of poor asthma control, lack of knowledge, and barriers to access to medical care and medications. Its environmental interventions address such issues as addiction to nicotine in tobacco, exposure to secondhand smoke, and unsafe home environments. It uses education to advance guideline adherence by clinicians and patients. FAM Allies helps children and families to connect with caring people, reduce hospital stays and support healthy lives. FAM is working to eliminate disparities in childhood asthma care through community organizing and advocacy, and increasing parent leadership skills. FAM works with healthcare providers to encourage them to address social and environmental factors associated with asthma as well as medical care.

Key Point (1): Partnerships

FAM Allies has 80 member organizations, a few of which include:

- Most hospitals in the city of Milwaukee (Aurora HC, Wheaton Franciscan HC)
- 16th Street Community Health Center
- Family House Inc.
- Milwaukee Health Department
- Foster Care (Children's Service Society of WI and Lutheran Social Services)
- Community groups
- Wisconsin Department of Natural Resources
- Milwaukee Public Schools
- Medical College of Wisconsin
- Milwaukee Area Health Education Center

Key Point (2): Health Outcomes

- Surveillance techniques
- Data agreements

Staff: Erin Lee manages the FAM Allies coalition which works to link and integrate activities coordinated by the various coalition committees. Erin coordinates community education initiatives for audiences including childcare providers, school staff, parents, foster care, kids, coaches, and the general public. Additionally, she coordinates community referrals to the FAM Allies Care Coordination and Case Management program.

John Meurer is the Director of FAM Allies. He is the Director of the Downtown Health Center.

Laurie Smrz is the Asthma Program Coordinator at Children's Hospital of Wisconsin. She coordinates the FAM Allies care coordination and case management committee as well as the clinical quality improvement committee.

Vicky Edwards works for Family House Inc. She is responsible for community capacity building within zip code 53206. She is supported by the parent neighborhood organizing committee. The involved parents are working on agreements between landlords and tenants to create and maintain asthma friendly housing.

Jennifer Cohn works for the Medical College of Wisconsin. She coordinates surveillance and evaluation efforts, as well as IRB protocols for FAM Allies programming.

Partners: Kristen Grimes serves as the Wisconsin Asthma Coalition Liaison and coordinates Allergist Outreach training sessions throughout the state.

Kathleen Levac is the FAM Allies Steering Committee Chair. She runs a business called Health and Wellness Enterprises, Inc.

Aurora Health Care is the largest health care provider in Wisconsin. Aurora sponsors many departments that are linked through FAM Allies programming:

- Aurora Visiting Nurse Association employs an asthma nurse case manager that provides services to FAM Allies patient referrals.
- Aurora Parish Nursing places nurses in churches throughout the community. FAM Allies education programs are linked to those churches.
- Aurora St. Luke's supports 2 respiratory therapists that provide patient education to groups of students in several local schools. Qualifying individuals are referred to FAM Allies care coordination and case management programming.
- Aurora School Based Nurses are also linked to FAM Allies care coordination and case management activities.

FAM Allies has been able to provide small contracts to various Aurora programs; however, Aurora staff generally participate as in-kind donations.

16th Street Community Health Center (SSCHC) – 16th Street Community Health Center offers a grass roots experience, Latino connections/shared models and lessons learned. SSCHC provides outreach to workers who are multi-trained on lead, asthma, and injury prevention. This is included in the WIC program.

Family House Inc. – Family House Inc. is almost 20 years old. Vicky Edwards has been involved with this organization for two years, going door-to-door to identify families with asthma and provide support. She has contacted over 280 families within the county. People move a lot and it's difficult to maintain contact with them. They encourage core groups to continue to be engaged so they can have their own victories. Their goal is to encourage others to join.

The FAM Coalition is very sensitive to the needs of Family House Inc., and they offer resources to this facility. One way to revitalize the neighborhoods is to receive assistance from community-based organizations.

Family House Inc. employees are very instrumental in stretching their resources. Vicky was very persistent in working with the coalition when her funding ran out. Family House Inc. has been able to increase services to their clientele via FAM Allies support:

- They provide free medications to their clients through coordination of FAM Allies pharmaceutical representatives that donated to the Family House Inc Clinic
- Coordinated a Christmas party providing gifts from FAM Allies members to 12 families in the community.

Future plans include expanding efforts to assist with psycho-social issues. Assistance is provided to a child and/or a family to release them out of a crisis mode. Additionally, parents are interested in creating homes which are affordably healthy in 2007. The program links to the lead abatement programs that exist through the Milwaukee Health Department to receive new windows, and in establishing relationships with Home Depot store to provide low-cost materials for home repairs.

Milwaukee Health Department ((MHD) – MHD provides care coordination and case management nursing support for referred families that have no health insurance. Additionally, staff assists with FAM Allies community events and link to education that is provided to child care providers.

Community Groups – FAM Allies Committees work together to develop strategies, organize activities and develop methods to maintain strong community ties. Unique methods are used to motivate the families who live in the community to participate in program decisions and activities.

•FAM Allies builds on what already exists. The coalition evolved from academicians, health care providers, and community health educators/local health departments. They were strengthened by the state experts, national experts and Medicaid financing. More advances were made with the environmental specialists, parent leaders, and advocates.

•FAM Allies always share with the people in the community; there is no charge to attend their meetings and/or to receive educational materials. They share ideas and tools with other coalitions.

It is important to note that FAM brought together competing organizations from the medical society to bring physicians on board. This took almost one year to coordinate. FAM educates teams, medical champions, especially allergists and pediatricians, to improve medical services.

Health Outcomes:
Surveillance techniques – Asthma surveillance is conducted in schools, daycares, WIC locations, and other community sites, as well as in traditional health care settings. FAM Allies Surveillance and Evaluation Committee tracks and measures the health outcome goals and guides primary and secondary research activities. The qualitative, quantitative and intermediate outcomes/process data demonstrates the coalition's impact on the community.

The coalition's core goals are to improve the quality of life for children/families, reduce hospitalizations, emergency room visits, childcare and school absence due to asthma, and to eliminate disparities. Progress is measured by tracking these goals and the outcome data is shared with everyone. FAM Allies are committed to the principles that they agreed upon in 2001 which are listed below:

-to pursue concrete and attainable goals
-to include diversity in membership
-to foster mutual respect, understanding and trust
-to facilitate collaborative partnerships in activities
-to build on strengths and resources in the community
-to promote learning and empowerment that addresses social inequities
-to disseminate knowledge and findings to all partners
-to leverage coalition partnerships and enable each agency to expand its community resources to control asthma

Also, performance appraisals, reports and outcomes are provided to the coalition members, the community and to the funders.

Data agreements: Statutes prohibit the state from sharing individual level health information. HMO's can share individual data with the state. Hospitals are required to follow certain procedures when someone is requesting data to ensure the privacy and confidentiality of all patients. FAM has a data sharing agreement in place with Wisconsin Medicaid. In Milwaukee, IRB protocols are in place with Children's Hospital of Wisconsin. Results of research and analyses of secondary data are shared with the agencies participating in FAM, including ALA, City Council, School Board, and other organizations.

They also perform internal program and process evaluations.

Question: How did you set this project up?
Answer: This project was developed with a lot of planning, community involvement/academics and with assistance from Children's Hospital. Children's Hospital shared data so that they could get a sense of what was going on. Their costs are $30,000 a year. They do have agreements with the State and the University of Michigan to retrieve data and hospital utilizations. They did research Children's Hospital, the Medicaid system, ambulatory visits and they targeted certain

communities. These procedures were performed so that they could engage the parents. They do have data agreements with the State of Wisconsin, Department of Human Services, Medical College of Wisconsin, and the Department of Public Health. John mentioned that there is an article and/or pamphlet which inform you about how to start a project**.**

Empowering – FAM Allies help to empower parents who live in the community by providing training, employment, child care, transportation and small compensations. It is more difficult to provide long term funding. FAM Allies assist the parents by finding out exactly what they need and providing various resources to them. Parent leaders are being developed to take over chair roles within various FAM Allies committees, and they receive a small stipend to perform work done in-kind.
Worked together and provided educational information to families in the community. The medical staff pulled together the payers and providers to assist with this matter.
Milwaukee has had the biggest reduction of hospitalizations by county. They are saving the State money. Large organizations are committing staff time, giveaways, and $550,000 in in-kind resources.

Tool Kit: The Asthma Tool Kit was developed two years ago as a resource and it contains the best ideas from different agencies. Included in the Asthma Tool Kit are: the national guidelines, asthma management plan, clinical tools, and community resources. There are two versions of the patient education materials that are included in the Asthma Tool Kit: one set in English and one set in Spanish. A lot of this information was compiled by people using their own experiences, parents, and by searching through delivery systems. The Asthma Tool Kit was reviewed and developed by local members. The Asthma Tool Kit can be emailed as a pdf file if requested and/or sent to you via U.S. Mail. They are currently updating the Asthma Tool Kit to be consistent with the new NAEPP guidelines. The updated toolkit will be produced digitally for ease of use online.

Milwaukee Healthy Homes Project: Data analysis and tests were performed which resulted in the following procedures:

- vacuum sampling
- follow-up home visit after 3 months
- Staff employees and the Public Health Department employees visited parents in their homes to demonstrate to the parents how to clean their homes properly, to provide cleaning supplies to them and classes were arranged for the parents to attend.
- Managers at the Home Depot stores were contacted in order to work out some type of agreement so that the people in the community could receive a discount towards their purchases.
- samples for two types of dust mites, dog dander, mice urine and cockroach
- Data analysis of 180 children were performed and it was recommended that children be tested for allergies.
    - 60% to 65% of the children did have allergies.
        - One child did test high for mice allergies. It was discovered that the couch contained mice allergens. They needed to find out exactly what's in the

home, what the child is allergic to and if houses have evidence of those allergens (i.e., cats)

- Surveys were performed at three different schools and at a WIC site concerning the 3rd, 4th, and 5th grades classes. There are two bilingual schools in this area. Approximately 2,000 surveys were sent out. Parents were angry about the fact their children have asthma. Parents were given mattress covers, pillow covers and other items useful for protecting.

They followed-up with the care giver "Quality of Life Survey" and developed actions plans to determine whether or not anyone smokes in the house.

Question: How did you evaluate for the WIC site?
Answer: They selected a WIC site which involved a lot of children from low income families and target areas.

Question: Have the school nurses been able to identify the asthma problems?
Answer: Milwaukee Public Schools have nurses employed through MPS, nurses from the Aurora School Based Health Program, and nurses from Children's Hospital and Health System. Parochial schools may have an Aurora Parish Nurse serving the school. Not all schools have nursing services in Milwaukee. Nurses working within MPS have collaborated on certain services. FAM Allies supports school nurses with speakers, programs, and the case management care coordination referral system.

MPS has noticed performance differences in schools that have nursing support. Slowly, more schools are adding nursing services.

They write research protocols and include informed consents and HIPAA Authorizations, making it easier to communicate freely. They are willing to invest in nurses and nurse practitioners.

Question: Where does their Asthma Tool Kit actually go?
Answer: Their Asthma Tool Kits are distributed through the Allergist Outreach programs, teach Asthma Management programs (for nurses, rep therapists, health workers), and by outside requests.

John emphasized the importance of having an experienced grant writer on staff. Also, surveillance information is valuable in grant writing.

Asthma Alliance of Indianapolis:

Attendees: Robin Costley, Chair/Asthma Program Manager**,** Marion County Health Dept.**, Lisa Cauldwell,** Indoor Air Specialist/Community Outreach Committee**,** Marion County Health Dept**., Danette Fariss,** Co-chair of Alliance/Pediatric Asthma Educator, St. Vincent Hospital**, Annmarie Thomas, CRT/Pediatric Asthma Coordinator**, IUMG Primary Care**, Marcie Memmer,** INJAC Program Director**,** Chronic Disease/Asthma Program, Indiana State Dept. of Health

The Asthma Alliance of Indianapolis (AAI) was initiated in 1997 and includes the Marion County Health Department, American Lung Association, Anthem Blue Cross Blue Shield, and five major Indianapolis hospitals: Clarian Health Partners, St. Vincent Children's Hospital Pediatric Asthma Program, St. Francis Hospital Respiratory Therapy Program, Community Hospitals, and Wishard Health Services. The AAI is strengthened by healthcare professionals with varied backgrounds, including pediatric medicine, nursing, respiratory therapy, social work, and environmental health. A multidisciplinary approach to asthma education, prevention, and treatment has allowed for a comprehensive support program that serves the local community. The mission of the AAI is to provide individuals affected by asthma with the knowledge and skills to improve their health and quality of life. The AAI program includes a local university respiratory therapy program, a unique referral service, a home visit database with environmental outcomes, a schools coordinator through a one year EPA grant that ended in December 2006, and environmental trigger training with a remediation component.

Key Point (1): Integrated Health Services

- Unique asthma referral service
- Home visit database with environmental outcomes
- School health coordinator database
- Contract to carry asthma medications at school

Key Point (2): Partnerships

- Annual World Asthma Day poster contest
- Head Start
- Corporate sponsors
- Neighborhood clinics

The Marion County Health Department's (MCHD) commitment is a major component of the coalition. The Health Department has amazing, dedicated staff that go the extra mile to help clients. The Health Department does have a social worker program that they call on when they encounter psychosocial issues, but most of time the champion health care visitors have already established a relationship, so they will deal with as many psychosocial issues that they can.

Unique Asthma Referral Service: Many clinics, physician offices, and managed-care organizations have implemented asthma-management programs. AAI offers the extension of resources and free services to these clients through its Asthma Referral Service, which was initiated in 2001. Home environmental assessments and smoking cessation services are examples of this extension of resources as well as the provision of needed management tools to families who would otherwise be unable to obtain them. A database was designed to record and track information from this referral service and is part of the electronic charting system, Insight, for MCHD. Remediation data is also collected and reported to interested parties and used as coalition building leverage for future endeavors. Reports are sent to the referral source and healthcare provider with proper documentation; Health Insurance Portability and Accountability Act of 1996 (HIPAA). This referral system helps the asthma care team across the board,

including school personnel. The client also receives a copy of what triggers were identified and what education and training were given during home visits. The numbers of visits varies for each client in relation to the assistance needed and follow up to assess results, both negative and positive. The forms are made available to the referral sources (which were designed in conjunction with the public health nurses), and identify the environment, the prescriptions, and other preliminary information so that during the home visit, the educator can incorporate education on medications and proper support techniques, as well as addressing other related educational needs with each client. The reports demonstrate if they are adhering to recommendations (environment, med plan, etc.).

Question: Who initiates referrals?
Answer: A variety of sources refer their clients to the Asthma Referral Program including schools, hospitals, clinics, community based programs, other MCHD programs and self referrals. The initial referral comes to the MCHD's Asthma Specialist, Robin. She makes the initial visit and then brings in any needed resources as allowed by the family. This asthma referral service can tie into all programs. If at least 1 Environmental Trigger is eliminated, it is considered success. If Robin sees a major problem, she will refer the problem to the Indoor Air Specialist at MCHD , Lisa Cauldwell, since she has the expertise in city code enforcement.

Lisa will often perform tandem visits to make families more comfortable and to gain trust for future visits. While handling a referral, finding out if any allergy testing has been performed is important and use this as a target point for environmental visit. Referrals are specific to "problem" cases, but not for all asthma patients. Certain problems are being referred to the specialists. Lisa also has ability to check for code violations. They capitalize on the MCHD staff that's already in the homes for other reasons. In addition, other MCHD staff working in homes participate in outreach, and are trained to spot asthma triggers.

Pets are often found in the homes. Vacuuming properly is highly emphasized. During the first year of the referral service, a pharmaceutical company provided funds to purchase HEPA vacuum cleaners for those families in need. The MCHD Lead Program has loaner equipment for families, but the problem is that vacuums are returned with a lot of dirt inside of them and storage space is an issue.

There is no charge for the services obtained through the home visits.

School health coordinator database: A lot of referrals are issued by the schools themselves. School absenteeism and urgent scheduled visits are being tracked, which is hard to do, but is successful if a school nurse is on staff at that particular school. A computer database is being utilized to print out reports of activities and access to the schools. They try not to duplicate activities or investigations unless asked to do so. Training is being staggered throughout the year for school employees.

It was recommended that nebulizers and Action Plans be given out to school employees as a part of the trainings. These are often provided through the partners or corporate sponsors.

QI systemic changes in practices:

- Insight database
- School Health Coordinator database
- Database of community outreach activities
- Database of membership

Contract to carry asthma medications at school – AAI created a "Contract to Carry" once the Indiana law was established in 2001, allowing children with asthma to carry inhalers. This contract has a questionnaire of seven questions that parents need to ask their children. If the parents answer "no" to any of the questions, then they need to consider that their child may not be responsible enough to carry their own inhaler. The contract is signed by the student, parent, health care provider, and the school personnel responsible for treating the child's asthma. Then, the student may have the privilege to carry their own inhalers. This privilege may be revoked if they violate the contract. This contract has helped to make school personnel more comfortable with students carrying their own inhalers and involves the whole team caring for the student's asthma.

High-Performing Collaborations & Partnerships: AAI membership consists of more than 60 diverse partners from local health care, educational, business, and social service organizations. In addition to AAI leaders who organize, direct, and provide program administration, core members assume specific roles and responsibilities. Cooperating members publicly support AAI and encourage others to contribute time and action, and community supporters sustain the coalition at key intervals. Area schools continue to be an important partner in AAI outreach and education efforts. Education programs constitute the backbone of services offered by AAI. AAI instructs students, school personnel, custodians, and parents.

AAI has worked with the Washington Township School Corporation through the Asthma Educator, Danette Fariss, for St. Vincent Children's Hospital Pediatric Asthma Program. The four years Danette has worked with this township, she has been able to strengthen and increase the capacity of local and state education associations to work with asthma collaboratives to improve the health and well being of young people with asthma. St. Vincent has also been a strong supporter of the annual golf tournament fundraiser.

Clarian Health Partners has provided strong support through entire life of AAI by providing educators, committee chairs, and development of current governance board, website sponsor and gold corporate sponsor. Annually, Clarian offers support in staff funds, sponsors the AAI website, and assists in planning of World Asthma Day.

Partners include:

- Indiana Joint Asthma Coalition (INJAC), Indiana State Department of Health Asthma Program, eleven local Head Start programs, school districts, ALA, all local hospitals,
- Realtors/landlord associations and custodial groups
- Advantage, BC/BS, MDY Health Plans involved
- Pharmaceutical reps are with AAI and major players; provide financial support for many of the activities

Cooperate sponsors include:

Anthem Blue Cross and Blue Shield, Clarian Health Partners, Indiana State Department of Health Asthma Program, Marion County Health Department (administers the AAI), St. Vincent Children's Hospital Pediatric Asthma Program, AstraZeneca, GlaxoSmithKline, MDwise Hoosier Healthwise, Robert's Glass and Service, Sepracor, St. Francis Hospital Respiratory Therapy Department, American Lung Association of Indiana, IUMG Primary Care, PhRMA/ RX for Indiana, Praxiar Home Healthcare, Wishard Health Services, Advantage Health Solutions, and Smokefree Indiana.

Head Start – Helps form relationships and works with families. All children enrolled in Head Start have been screened since 2000. A part of the screening, if the family answers yes to any of these 5 questions, they are referred to the AAI asthma referral service. This collaboration provides families with education, resources, and materials that are needed to keep asthma in control. 2,000 children are screened using a 5-question paper tool screen. Each year the AAI provides educational training to all school staff. Students were given chest vest activities (i.e., drawn lungs, etc.) and they took them home to show their parents. Three or four public health nurses in various districts have been enthusiastic and champion for the AAI. Parents are trained at each Head Start center at the October meetings, reaching around 200 parents. To establish a relationship with Head Start, find the community liaison.

Schools – Offers a variety of support resources, including World Asthma Day poster contest, using MN's Coaches Clipboard "Winning with Asthma", free workshops, action plans, and emergency plans.

Action-oriented meetings – 4th Friday of every even month, 1 ½ hours with committee reports and exchanges ideas and concerns.

AAI Program Write-up – New projects to keep members involved, communication through listserv and website for members that are unable to attend meetings.

Annual World Asthma Day – Poster Contest: Asthma treatment begins with education, and education begins with awareness. AAI celebrates World Asthma Day as a way to increase awareness of asthma prevention and promote asthma education in Marion County. In honor of World Asthma Day, AAI sponsors a poster contest for children in kindergarten through eighth grade. Posters depict student's perceptions of asthma, asthma prevention, or asthma education. Posters are displayed at various sites in Indianapolis in recognition of students' artwork and their efforts to help educate the public about asthma. The winning poster is displayed on a billboard in the neighborhood of the winner's school, courtesy of Clear Channel Communications. Winning posters may also be displayed on note cards and t-shirts and are used in presentations. The awards ceremony takes place in one of the major malls in Indianapolis. A major pharmaceutical company sets up and funds spirometry/asthma screenings with physicians on site to interpret results for participants. Last year, AAI was able to secure the support of 25 sponsors for World Asthma Day. Information on poster contest is available online.

Diverse partners and community inclusion:

1. Radio Disney
2. Corporate Sponsors

- Can take 3 to 4 years to foster agent interested in sponsoring.
- Find the community connector in your own group.
    - E.g., found a golf course interested in supporting Golf Outing.

Find good community support, especially via Pharmaceutical Representatives. Maintain a partner's list through a computer database. AAI tracks program numbers and not individuals. Annual Golf events are organized to raise money. The Pharmaceutical Companies have sponsored the AAI booth at the largest Black Expo Exhibit in the United States. Also, sponsors provided free booths at the World Asthma Day events. Corporations usually give the typical amount of $500. Most hospitals are required to give back to the community and therefore, you should seek their assistance. Tie into chronic disease manager because they are tied into grant funding opportunities.

Golf Outing Example: Since 2003, AAI has conducted an annual golf tournament aimed at raising awareness about the challenges of living with asthma and targets business organizations. For the past three years, dozens of novice and seasoned golfers have participated to learn more about asthma management and to meet health professionals working with families with asthma – all while having a great time on the links. This event functions as the sole fundraiser for AAI. Revenue is used to purchase needed asthma-management tools for families identified through the asthma referral service. Items such as roach baits and gel, dust mite pillow protectors, nebulizers for school clinics, nebulizer kits, spacers, peak flow meters, etc.

Sponsor levels:

Platinum	$1000 >
Gold	$ 500
Silver	$ 250
Bronze	$ 100

$5,000 (from larger groups)

Supporting Health Fairs: AAI participates in many health fairs throughout the community. AAI participated in 23 health fairs in 2004, 30 in 2005, reaching more than 16,000 individuals. Venues range from the Indiana Black and Minority Health Fair and Kids Back to School Day, Indiana Kids Environment Lead Conference, Indiana Association of School Nurses conference to smaller, more intimate settings. AAI participates in as many requested health fairs and general asthma presentations as possible, including faith-based organizations, local senior citizens' organizations, and school-based health fairs, community centers, and inner-city youth camps. In 2006, AAI conducted 226 workshops and health fairs and reached over 28,000 participants.

AAI has been able to provide needed items for the children with moderate to severe asthma. Funds and donations were made to purchase and distribute these items. Just removing roaches can provide a sense of accomplishment for some of these families and it opens the door to focus on other management issues in return visits. Other services available to the community include education to schools and organizations about proper pest-management practices, maintenance activities, and similar guidelines established by the Environmental Protection Agency in regard to environmental interventions

Driving Force: A past community needs assessment showed the potential need to address asthma in the community. Includes using Healthy People 2010 as a guide. Other Indiana areas have done assessments as a result of MCHD's assessment experience and recognize the importance of addressing asthma. Currently there is a housing program at MCHD – unique to Marion County. This program and making the connections to other programs helps support the community needs.

Background of Educators: MCHD has a great mix of Respiratory Therapists, nurses, environmental specialists and other staff employees. Other departments have people educated on asthma triggers. Staff is trained on the five common asthma triggers: smoke, mold/ moisture, pets, pests, and dust mites.

Part of the local University Respiratory Therapy programs exposes new graduates to the area of public health and supports the AAI goals.

AAI cross-trained the housing inspectors and other staff at MCHD because they were already in homes and it was easier for them to perform enforcement duties. New construction building inspectors often ask a lot of indoor environment questions, so Indoor Air Specialists use these as teachable moments. Health Departments are "dumpster jumpers", often finding resources where they can.

Example of cross-training success are the school inspections – At the beginning of school year, an inspector was called out to a school because a child was experiencing asthma symptoms each day at school. Through the inspection, urinal cakes were identified as the trigger for this child. These types of school visits open the door for MCHD to educate on other asthma triggers.

Educators & their support – Nominal School IAQ Testing:

- CO, CO_2, Temperature, relative humidity (RH)
- Visual, odor, and noise-based indicators
    - Performing an asthma trigger assessment isn't rocket science
- Educators can help determine the best ways to reduce the triggers in their general areas.
- Public education & promotion in community goes hand-in-hand with the school support

Other Services:

Smoking cessation, air quality services, asthma education, other public health services.

Database and Schools:

- Washington Township helps to collect treatment data
- All meetings, minutes, activities, etc. available online at http://www.asthmaindy.org
- School Health Coordinator database

Question: How do you get people to participate if they don't think it's their job?
Answer: Really more of a time issue, getting people to donate time or training some of the staff who go out into the community to bring together their resources/contacts. Most of it includes

educating Public Health Nurses & MCHD staff on asthma triggers, general med & activity issues - some are members of the coalition.

Genesee County Childhood Asthma Taskforce (GCCATF):

Attendees: Jocelyn Faydenko, Genesee County CATF**, Caren Faydenko,** Genesee County CATF**, N. Pauline Sidiropoulos,** Social Work Case Manager**, Joni Zyber,** Asthma Disease Manager**, Jan Roberts,** Coordinator Task Force**, Michelle Cox,** Respiratory Therapist**, Michelle Debernardi,** Disease Management Coordinator**, Terry Love**, Associate Director, Wellness Center, Kettering University

GCCATF provides excellent service to its community through connections with health providers and community organizations. The GCCATF was established in 1998 and has approximately 50 Task Force members. The organization has strong community ties, which include links through faith-based groups, the local health department, and several local school districts. Unique aspects of the Task Force are an in-home assessment tool, local physician education, and strong hospital support. GCCATF also supports an asthma camp which is co-sponsored by Hurley Medical Center Flint. Key process and health outcomes feature complete home assessments, telephone coaching, and emergency room interventions. This work has resulted in decreased emergency room visits, decreased asthma hospitalizations, and improved quality of life factors. The Childhood Asthma Task Force was established to:

- educate and advocate for effective and consistent policies to manage asthma triggers
- control childhood asthma thru research & shared human/financial resources
- to address the serious problems of asthma in the community

The University of Michigan – Flint's Project for Urban and Regional Affairs (PURA), Priority Children (formerly Priority '90'), and the American Lung Association of Michigan, initiated a task force on childhood asthma in September of 1997. The main focus was to establish asthma management priorities to be addressed and develop goals to be achieved by focus groups comprised of member representatives from the fields of health, environment and education.

There are several workgroups. The education focus group is concerned with the identification of students with asthma through:

- teaching awareness in the classroom
- educating the parents
- training the school staff
- creating a community-wide asthma education campaign involving better linkages between schools and the health profession.
    - community education by physicians to any lay person or organization that requests it.

Key Point (1): Environmental

- In Home Assessment Tool (IHAT)
    - Using the home assessment in terms of risk and use results to leverage outside resources

Key Point (2): Community Ties

- Faith-based community support
- SMART Coalition (tobacco)
- Local Intermediate School Districts
- Day Camp
- Local universities

In-Home Assessment Tool (IHAT): Genesee County developed a home assessment tool that is used to measure triggers in the home and estimates risk. The University of Michigan-Flint tested the tool for reliability and validity 2 times with repeat assessment of the tool having the same outcomes as the initial testing. .

- Risk severity index that actually gives a risk number after filling out the tool.
- Also, use EPA Assessment Tool for shorter visits
- We use the home assessment as a resource tool to procure needed items for our clients, from something as simple as getting a vacuum cleaner to assisting with getting a home built through Habitat for Humanity. We can also use it to demonstrate outcomes before and after intervention because of the numerical scoring.

Working with Families:

- Psychosocial – Many families have precarious situations, and are not good at using community resources or following directions. GCCATF works directly with families to help them with special needs, such as transportation, food baskets, etc. They visit the homes with nurses and deal with psychosocial, environmental, educational, financial and other issues.
- Need to work with parents – GCCATF's clinical care teams are involved with the continuing education program which provides the latest asthma information necessary to educate parents and children about environmental triggers. Once GCCATF clinicians assess environmental triggers, families are then educated on identifying their personal environmental triggers inclusive of remediation techniques and referrals as needed. Certain procedures are followed to eliminate problems, which are listed below:
    - Discuss the In Home Assessment Tools used by GCCATF to further identify the environmental triggers and help (minimize/eliminate) environmental triggers.
    - Question family and observe every room in the house, GCCATF clinicians survey reveals information on home and school/work environments, personal behaviors such as smoking, or seasonal or other allergies that may worsen asthma symptoms.
    - CATF clinicians work diligently to ensure a patient understands their personal triggers. It is important to work with family to lessen initial resistance to an in-home assessment to allow for improved outcome responses.

Working with Parents: Sometimes there is resistance from some parents when they do not take asthma seriously or only see asthma as an episodic disease as opposed to a chronic disease. Parents are in "Denial".

Parents are involved as team members to help get messages across to the community. For example, Terry Love is a committee member and a parent of an asthmatic child. Terry helps to

get the message out at local school functions because being a parent she relates to other parents on a more personal level.

Initially, they were lacking political involvement. However, they recruited Brenda Clark (state representative) and Debbie Stabenow (U.S.Senator) who sent representatives to sit on the disparity committee. One of the representatives is also a parent of a child who has asthma and who has become a vocal/active component in the coalition.

Question: How do you address transient patients?
Answer:

- 50% of patients are transient. It is challenging.
    - Swing by when on other appointments.
    - Knock on doors – Go at 8:00 a.m.
    - Leave notes
    - Get cell phone numbers
    - Meet them at local shelters, libraries, etc.

Working with schools: Working with Hurley Medical Center Disease Management School. Education is one of the primary goals and representatives of Hurley closely with Genesee and Flint Intermediate School Districts (FISD/GISD), which consists of 17 school districts plus charter and private schools to assess their needs.

There is a lot of school-based education about disease-based management with support given for assessment (150 patients a year). Home assessments with follow-up are completed to try to decrease missed school days. GCCATF works with coaches, gym teachers and all other staff to assist them with understanding asthma and what the goals and options are for children with asthma in the school setting.

Action Plans are useful for schools:

- Schools require them.
- Take them to doctors/hospitals
- Ask to sign-off – force conversations with staff about students w/asthma.
- Library prints out information for staff and families of students.

Worked with the state to get an inhaler law passed to allow students to carry their inhalers with an emergency plan in place.

GCCATF uses a school-specific Asthma Tool (a folder with materials) for School officials developed in conjunction with the state's asthma school and quality improvement committee.

- Principal
- Facility Managers
- Coaches & Gym Teachers
- Bus Drivers

- 55% response rate for information provided in the folders
- Follow-up calls after folders were sent out

- Piloted the Tools first

Asthma 101 (Developed by the ALA with the asthma task force): The American Lung Association (ALA), Genesee Intermediate School District, the Childhood Asthma Taskforce and the Hurley Medical Center Disease Management Team partnered together to provide Asthma 101 trainings. This training is for schools and its personnel, caregivers at educational nights for families, and children with asthma, coaches' in-services, and school districts outside of the area. Also, the asthma school initiative and the annual Asthma Walk both provide on-site education and interventions with a local pulmonologist. Asthma 101 is provided to any individual classroom as needed.

Schools are required to have asthma education one time a year by the state school board. The GCCATF will perform one visit (if necessary) and provide education (if they feel that it is needed and they are invited).

Question: How did you pay for Asthma 101?
Answer: Started off with no money and they made their own brochures. Then, a $5,000 initial grant came from the community foundation to develop professional boards. The biggest costs were the initial development of boards, mouth pieces and brochures because the Asthma 101 kit is very interactive. It allows them to learn how to use spacers, peak flow meters and understand what asthma feels like.

Some schools don't like "Tools for Schools" because they are under the opinion if you don't acknowledge a problem, you don't have to fix it! The coalition still intervenes as much as they can with the schools but financial problems remain a problem.

Data Surveillance/Results: The community was rated as the second in the state for asthma morbidity 5 years ago. Since then, the community has decreased to fifth in the state for asthma morbidity and mortality. They are higher than the national average for asthma morbidity and mortality, and they recognize that this program must continue. Asthma is recognized as the third most common reason for hospital admissions in the county for children. GCCATF has been very active in the community and have been providing assessments to the community.

Jan Roberts and the Disease Management Team worked together to reduce emergency room visits, hospital admissions, and missed school days due to patients with asthma. Patients are given an Environmental Home Assessment, which uses either the EPA Home Assessment Tool or the locally developed IHAT which tracks decreases in environmental triggers. The results from the first initial GCCATF's data collection were missed school days dropped from 35% to 25%, and days with restricted activity were reduced from 35% to 13%. Emergency room visits were decreased by 52% and cost of the hospitalizations were reduced by 49%.

After the first year of the program, the hospital estimated that $660,000 was saved from the decrease in emergency department visits and decrease in severity of the asthma when a hospitalization did occur.

Quality of life – Every patient is also provided a written asthma action plan for home, school or daycare. GCCATF tracks outcomes through a quality of life assessment tool. (Juniper Quality of Life). Asthma disease management team also has data outcomes in community such as tracking hospitalizations, emergency department episodes, and number of days in intensive care. They also track "soft" measures (school days, inhaled steroids, physical activity, and quality of life and Juniper quality of Life).

Action Plan – Results and actions plans are also shared with health care providers, schools, and other GCCATF outreach workers associated with the family/parents of the child with asthma. Parents are interviewed twice to examine the barriers the families face. The report leads to a written asthma action plan for the family to follow at home, school or at daycare. GCCATF's data collection resulted in 24 patients with action plans to begin with, and increased to 85 after three months and 123 after six months.

Community Partners: GCCATF collaborates on a regular basis with the ALA, faith-based organizations, FACED, Parish Nurse Organization, State Organizations, local universities and the Genesee County Medical Society Environmental Committee to provide various types of assistance to families and other community members which are listed below:

-provide Asthma 101 to schools
-asthma school initiative
-annual Asthma Walk
-provide onsite education and interventions with a local physician at different events
-provide education at local health fairs
-give lectures at the individual churches
-provide resource referral for individuals
-provide in-service for the Michigan Pharmacy Association
-provide a site location and asthma camp for children with asthma
-provide asthma education to the local health plans for their own knowledge
-to provide information to health plan and physician on their participating clients

Always looking for diverse group members to fill needs & constantly add to the group expertise

Partner with City School Nurses, although there are not many. There are only four school nurses for the City of Flint. GCCATF partners with GISD nurses to provide education and resources for them as needed

Health Plan – GCCATF provides asthma education to the local health plans and to their clients.

SMART (tobacco) – The SMART Coalition helps to create a smoke-free environment such as restaurants, local businesses, and they are working to make schools smoke-free 24/7. Health department environmental sanitarians, in conjunction with the task force, handles school/work issues and lead concerns, anti-tobacco coalition, landlord groups, and medical societies.

Faith-Based Education – (Faith Access Community Economic Development)(FACED):

Faith Based Community – GCCATF collaborates with faith-based organizations including FACED and the Parish Nurse organization for educational support at local health fairs, lectures at the individual churches, and as a resource "referral" for individuals. Faith Access to Community Economic Development is a coalition of 67 inner city churches. Working integrally with the faith based community allows GCCATF to more credible force especially in the African American Community. A lot of community education is provided, such as "Living with Asthma" presentations, which are held at local libraries, malls, schools, and community centers. Website is FACED.ORG – Safety & trust through Churches

Parish Nurses – Jan Roberts is locally known as the "go-to" person for anything asthma related. As a trained parish nurse, she is well-known throughout many of the local churches in the community. At this point in time, asthma services are offered free-of-charge, including home visits. The parish nurse organization also participates in education at local health fairs, lectures at the individual churches, and as a resource referral for individuals.

Asthma Camp – The GCCATF also runs a day camp for children with asthma as well as an asthma support group for teens. Parents want their kids with asthma to exercise but are concerned about its impact on the respiratory health of the children. However, parents are more accepting of this program since it is supervised by the health care workers who are familiar with asthma. Camp is for 2 days and they have partnered with local universities, YWCA and a local camp in the past.

Other Partners:

- School, daycare, PTA, foster care
- Teenager and Family Support Groups
- Drug representatives provided money and food at these events.
- Health and Fitness center & Children's Museum offers their facilities for meetings.

Communication with Physician: Primary care physicians receive the in-home assessments findings from the initial home visit. This includes information on whether patient is properly/ improperly taking their medications, proper/improper use of asthma tools, and any other barriers evident during the visit. GCCATF will follow-up with the physician at three-months, six-months, and one year. They also educate the patients and their families on self-management and communication with their primary-care physician. GCCATF communicates with the schools to make sure they have an appropriate asthma action plan in place (has been developed by the asthma disease management team and the primary-care physician)

Dr. George Zuerikat, MD is the Director, of the Hurley Medical Center's, Pediatric Intensive Care Unit and local asthma clinic. He has been very supportive in caring for children who have not been diagnosed with asthma and in performing a one-time evaluation on children so that parents will be eligible to apply for the Children's Special Health Care Services.

Need more doctor availability – Dr. Brian Nolan, Dr. George Zureikat and Dr. Suresh Anne provide lectures to physicians about asthma in their offices, at seminars, during Grand Rounds and in other local settings. They serve as a resource for the Asthma Disease Management Team when clinical interventions are needed with independent practitioners.

Provider Education: Michigan Asthma Resource Kit (MARK) Tool Kits. It is located on Michigan's Asthma website at http://www.getasthmahelp.org.

Emergency Room/Education: GCCATF worked with the Michigan Department of Community Health (MDCH) to implement the FLARE plan emergency discharge instruction in hospital emergency departments and free-standing emergency clinics. Several members of our taskforce, including pharmaceutical representatives, health plan personnel, RN's and RRT's, participated in implementation. Prior to developing the emergency department intervention, GCCATF worked with the Emergency Department Director and the hospital Chief of Staff to identify disparities between clients implementation using primary care providers versus emergency department visits for asthma care. FLARE Plan information also available on Michigan Asthma website at www.getasthmahelp.org/FLARE_PDF.

In working with the GCCATF's clinical care teams and community outreach programs, the providers are never without the latest resources on environmental asthma management. Continuing education is the key to ensuring that providers are aware that help is available.

GCCATF'Staff and Roles:

Jan Roberts, RN, C AE-C has been involved with this task force since 1998 and the coordinator since 2002. She works at the Hurley Medical Center in the Pediatric Asthma Disease Management Department, and she serves as the clinic arm for the task force. Jan serves on the State Quality Initiative work group which has been instrumental in developing programs and distributing state programs, such as the MARK (Michigan Asthma Resource Kit for physicians) and the Nurse Educator Tool Kit. She sits on both the Michigan Consortium of Asthma Coalition (where she previously held the role of chairperson) and the Michigan Asthma Advisory Committee and assisted in the revision of the Michigan asthma plan. The other vital members of the disease management team include Joni Zyber RN and Pauline Sidiropoulos MSW.

Evilia Jankowski, RN is employed by the Genesee County Intermediate School District as Health Education Coordinator for the county's 17 school districts, including charter schools. She serves as Clinical Coordinator for the health teams and registered nurses throughout for Genesee County school districts. Evilia serves as the Coordinator of the Education Workgroup for the GCCATF and plays an active role in the State's School Workgroup.

Teresa Bourque, RN, MSN is a hospital-based Supervisor over the Disease Management Program. She is the go-between to assist in setting up computer-based programs so members can extract data and outcomes as needed. Teresa has been very supportive in any and all endeavors, allowing GCCATF to have in-kind time for services with the task force along with the Disease Management Program.

Terry Love, MA LPC is the associate director for the Wellness Center at Kettering University. She is currently the coordinating member for the Health Disparities Ad-Hoc Committee for the task force. Her duties at the university include mental health counseling, and working with disability and wellness issues. This fits with the mission/vision of GCCATF.

Patty Inman, BA, works with the American Lung Association on issues such as Asthma 101, Asthma Walk, smoke-free work places and other local and state issues.

Joe Reuther and Dorothy Gonzales, health department sanitarians, work a lot on school issues and are tied into the lead program, SMART/anti tobacco coalition, landlord groups, medical society, and working in low income neighborhoods.

Question: How is local Health Department involved?
Answer: GCCATF works with the Environmental Sanitarian, Joe Reuther, RS. He is involved with mold and lead program efforts. They perform one-on-one home visits when they have concerns about extensive mold. Joe partners with GCCATF to assist in mold remediation through his work with landlords and insurance companies.

No enforceable code used, however, "official" looking letters help encourage landlords to fix properties.